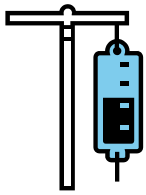
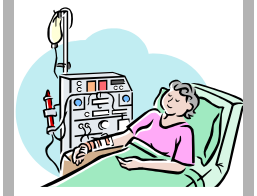
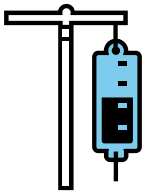






Dialysis Clinic Services

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

This publication supersedes all previous Dialysis Clinic Services handbooks. Published by the Montana Department of Public Health & Human Services, July 2005.

My Medicaid Provider ID Number:

MONTANA
Department of Public Health & Human Services

Table of Contents

MONTANA
Department of Public Health & Human Services

Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

Provider Relations

For questions about enrollment, eligibility, payments, denials, general claims questions, PASSPORT questions, or to request provider manuals or fee schedules:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In and out-of-state
(850) 385-1705 Fax

Mail to:

ACS
ATTN: MT EDI
P.O. Box 4936
Helena, MT 59604

Provider Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the G*eneral Information For Providers* manual.

Medicaid Client Help Line

Clients who have Medicaid or PASSPORT questions may call the Montana Medicaid Help Line:

(800) 362-8312

Send written inquiries to:

PASSPORT To Health
P.O. Box 254
Helena, MT 59624-0254

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

Dialysis Assistance Services Program Officer

(406) 444-4540 Phone
(406) 444-1861 Fax

Send written inquiries to:

Dialysis Assistant Program Officer
DPHHS
Hospital and Clinic Services Bureau
P.O. Box 202951
Helena, MT 59620-2801

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-5283

Key Websites

Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.mt.gov	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information and a link to the Provider Information Website. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning.
Provider Information Website www.mtmedicaid.org	• Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • PASSPORT and Team Care Information • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts • Links to other websites and more
CHIP Website www.chip.mt.gov	• Information on the Children's Health Insurance Plan (CHIP)
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides • FAQs • Related Links
BlueCross/Blue Shield of Montana www.bcbsmt.com	BlueCross BlueShield processes CHIP medical claims. For a CHIP medical manual, contact BCBS.

MONTANA
Department of Public Health & Human Services

Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for dialysis clinics. It includes a section titled *Other Programs* with information about other Department programs such as the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP). Other essential information for providers is contained in the separate *General Information For Providers* manual. Each provider is asked to review both the general manual and the specific manual for his or her provider type.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of *Key Contacts* at the beginning of each manual. We have also included a space on the back side of the front cover to record your Medicaid Provider ID number for quick reference when calling Provider Relations.

Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through notices and replacement pages. When replacing a page in a manual, file the old pages and notices in the back of the manual for use with claims that originated under the old policy.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails. Links to rule references are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office (see *Key Contacts*). In addition to the rules listed in the *General Information For Providers* manual, the following rules and regulations are applicable to the dialysis program:

Providers are responsible for knowing and following current laws and regulations.

- Administrative Rules of Montana (ARM)
  - ARM 37.86.4201 - 37.86.4205 - Freestanding Dialysis Clinics for End Stage Renal Disease
- Montana Codes Annotated (MCA)
  - MCA Title 53, Chapter 6, Part 2: 50-44-101 – 50-44-102

Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid provider's claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information For Providers* manual also has a list of contacts for specific program policy information. Medicaid manuals, notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information website (see *Key Contacts*).

Covered Services

General Coverage Principles

Medicaid covers most dialysis services when they are medically necessary. This chapter provides covered services information that applies specifically to dialysis clinics. Information on home dialysis is provided in the separate *Home Dialysis* manual located on the Provider Information website (see *Key Contacts*). Like all health care services received by Medicaid clients, dialysis services must also meet the general requirements listed in the *Provider Requirements* chapter of the *General Information For Providers* manual.

Dialysis clinic requirements (ARM 37.86.4201)

Dialysis clinics must be licensed to provide services in the state in which the clinic is located. The dialysis clinic must also be certified by the Centers for Medicare and Medicaid (CMS) to provide outpatient maintenance dialysis directly to end stage renal disease (ESRD) clients and provide training for self-dialysis and home dialysis. Dialysis services are provided to only those clients who have been diagnosed by a physician as suffering from chronic end stage renal disease (ESRD). Supporting documentation must be kept on file.

Services for children (ARM 37.86.2201 – 2221)

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including all services described in this manual.

Coverage of Specific Services

Medicaid follows Medicare's rules for coverage of most services. The following are Medicaid's coverage rules for dialysis services.

Drugs and biologicals

Most drugs and biologicals used in the dialysis procedure are covered under the composite rate and may not be billed separately. They include the following:

- Herapin
- Antiarrythmics
- Saline
- Antihistamines
- Mannitol
- Pressor drugs
- Antihypertensives
- Local anesthetics
- Glucose
- Dextrose
- Protamine
- Heparin antidotes

Some drugs not included in the composite rate may be billed separately. They include the following:

- Antibiotics
- Hematinics
- Anabolics
- Muscle relaxants
- Analgesics
- Sedatives
- Tranquilizers
- Thrombolytics used to declot central venous catheters

Administration of these drugs is included in the composite rate, but the supplies used to administer these drugs may be billed separately.

Epoetin (EPO)

Medicaid covers EPO therapy for clients who have been diagnosed with chronic end stage renal disease (ESRD). EPO is covered when administered in a facility.

Hemodialysis and peritoneal dialysis services

Hemodialysis and peritoneal dialysis are covered under a composite rate for the dialysis facility. When either type of dialysis is provided more than three times a week, it is billed and paid differently than when it is provided only three times a week (see the *How Payment Is Calculated* chapter in this manual).

Home dialysis training

Medicaid covers training for patients (and a helper/backup person) to learn to perform their own dialysis at home.

Home dialysis equipment, support and supplies

Medicaid covers home dialysis equipment, support and supplies. The patient has the option of having the facility provide the equipment under the composite rate, or of renting or purchasing such equipment directly from a supplier. The dialysis facility must provide the home dialysis patient with the following, which are included in the facility's composite rate:

- Periodic monitoring of the patient's home adaptation (including visits to the home, in accordance with a written plan prepared and periodically reviewed by a team that includes the patient's physician and other professionals familiar with the patient's condition)
- Emergency visits by qualified ESRD facility personnel
- Providing and arranging for supplies when dialysis equipment is provided by the facility
- Installation and maintenance of dialysis equipment when provided by the facility
- ESRD related laboratory tests
- Testing and appropriate treatment of water

- Monitoring the functioning of the dialysis equipment when provided by the facility

Some covered support services may involve indirect patient contact. The patient, for example, may need to consult with a nurse regarding dietary restrictions or with a social worker if he is having problems adjusting. The consultations may be by phone.

Lab services

Most lab services are included in the composite rate; however, the following lab tests may be billed separately to Medicaid when within the specified limit:

- Serum Aluminum - one every three months
- Serum Ferritin - one every three months

The following tests are included in the composite rate unless they are performed more frequently than specified. In this case they may be billed separately.

- ***Per treatment:*** All hematocrit, hemoglobin, and clotting time tests furnished incident to dialysis treatments
- ***Weekly:*** Prothrombin time for patients on anticoagulant therapy, Serum Creatinine
- ***Weekly or thirteen per quarter:*** BUN
- ***Monthly:*** Serum Calcium, Serum Bicarbonate, Serum Potassium, Serum Phosphorous, Alkaline Phosphatase, AST, SGOT Serum Chloride, Total Protein, LDH, CBC, Serum Albumin

Lab services are billed to Medicaid by the lab performing the tests.

Supplies and equipment

The supplies necessary to administer dialysis (e.g., needles, tubing, etc.) are included in the facility's composite rate.

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

The information in this manual does not apply to the Mental Health Services Plan (MHSP). Clients who qualify for MHSP may receive mental health services in addition to dialysis services. For more information on the MHSP program, see the *Mental Health Manual* available on the Provider Information website (see *Key Contacts*).

Children's Health Insurance Plan (CHIP)

The information in this manual does not apply to CHIP clients. For a CHIP medical manual, contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. Additional information regarding CHIP is available on the CHIP web-site and the BlueCross BlueShield website(see *Key Contacts*).

Coordination of Benefits

When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* later in this chapter). Medicare coverage is processed differently than other sources of coverage.

Identifying Other Sources of Coverage

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (see *Client Eligibility and Responsibilities* in the *General Information For Providers* manual). If a client has Medicare, the Medicare ID number is provided. If a client has other coverage (excluding Medicare), it will be shown under the "TPL" section. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' compensation insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long term care insurance

*These third party payers (and others) may **not** be listed on the client's eligibility verification.

Providers must use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Client Has Medicare

Medicare claims are processed and paid differently than claims involving other payers. The other sources of coverage are referred to as "third party liability" (TPL), but Medicare is not.

Medicare Part A claims

Medicare Part A covers dialysis services. To date, arrangements have not been made with Medicare Part A carriers for electronic exchange of claims covering Part A services. Providers must submit the claim first to Medicare. After Medicare processes the claim, an Explanation of Medicare Benefits (EOMB) is sent to the provider. The provider then reviews the EOMB, and submits the claim to Medicaid on paper.

When Medicare pays or denies a service

When dialysis claims for clients with Medicare and Medicaid are submitted to Medicare and Medicare:

Medicare Part A crossover claims do not automatically cross over from Medicare.

- ***Pays the claim***, submit the claim to Medicaid on a UB-92 form with the Medicare coinsurance and deductible information in the "Value Codes" form locators (39-41) and Medicare paid amounts in the "Prior Payments" form locator (54). See the *Billing Procedures* and *Submitting a Claim* chapters in this manual.
- ***Allows the claim***, and the allowed amount went toward client's deductible, include the deductible information in the "Value Codes" form locators (39-41) and submit the claim to Medicaid on paper.
- ***Denies the claim***, the provider submits a paper claim to Medicaid with the Medicare EOMB and the explanation of denial codes attached. If Medicare denies a claim because the service was not medically necessary, Medicaid will also deny the claim.

Submitting Medicare claims to Medicaid

When submitting a paper claim to Medicaid, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must include the Medicaid provider number and Medicaid client ID number. The Medicare EOMB and explanation of denial codes are required only if the claim was denied. When submitting electronic claims with paper attachments, see the *Billing Electronically with Paper Attachments* section of the *Submitting a Claim* chapter in this manual.

When a Client Has TPL (ARM 37.85.407)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability (or TPL). In most cases, providers must bill other insurance carriers before billing Medicaid.

Providers are required to notify their clients that any funds the client receives from third party payers equal to what Medicaid paid (when the services were billed to Medicaid) must be turned over to the Department. Amounts in excess of what Medicaid paid must be returned to the provider. The following words printed on

the client's statement will fulfill this requirement: "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first.

- When a Medicaid client is also covered by Indian Health Service (IHS) or the Montana Crime Victim's Compensation Fund, providers must bill Medicaid before IHS or Crime Victim's. These are not considered third party liability.
- When a client has Medicaid eligibility and Mental Health Services Plan (MHSP) eligibility for the same month, Medicaid must be billed before MHSP.
- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim form. Instead, notify the Department of the potential third party by sending the claim and notification to the Third Party Liability Unit (see *Key Contacts*).

Requesting an exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent to the Third Party Liability Unit (see *Key Contacts*).

- If another insurance has been billed, and 90 days have passed with no response, attach a note to the claim explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation directly to Medicaid in order to avoid missing the timely filing deadline.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
    1. The third party carrier has been billed, and 30 days or more have passed since the date of service.
    2. The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

When the third party pays or denies a service

When a third party payer is involved (excluding Medicare) and the other payer:

- ***Pays the claim***, indicate the amount paid in the "prior payments" form locator of the claim when submitting to Medicaid for processing.
- ***Allows the claim***, and the allowed amount goes toward client's deductible, include the insurance Reason and Remarks (formerly EOB) when billing Medicaid.
- ***Denies the claim***, include a copy of the denial (including the denial reason codes) with the claim form, and submit to Medicaid on paper.

When the third party does not respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Attach to the paper claim a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company).
- Include the date the claim was submitted to the insurance company.
- Send this information to the Third Party Liability Unit (see *Key Contacts*).

Billing Procedures

Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically or on a UB-92 claim form. UB-92 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within the latest of:

- Twelve months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- For claims involving Medicare or TPL, if the twelve month time limit has passed, providers must submit clean claims to Medicaid within:
  - ***Medicare crossover claims:*** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
  - ***Claims involving other third party payers (excluding Medicare):*** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All problems with claims must be resolved within this 12 month period.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual).
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid (see the *Coordination of Benefits* chapter in this manual for more information).
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the *Coordination of Benefits* chapter in this manual.

When To Bill Medicaid Clients (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid. The main exception is that providers may collect cost sharing from clients.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled client who was accepted as a Medicaid client by the provider, even if the claim was denied.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third-party payer does not respond.
- When a client fails to arrive for a scheduled appointment. Medicaid may not be billed for no-show appointments.
- When services are free to the client, such as in a public health clinic. Medicaid may not be billed for those services.

If a provider bills Medicaid and the claim is denied because the client is not eligible, the provider may bill the client directly.

Under certain circumstances, providers may need a signed agreement in order to bill a Medicaid client (see the following table).

When to Bill a Medicaid Client (ARM 37.85.406)

	• Client Is Medicaid Enrolled • Provider Accepts Client as a Medicaid Client	• Client Is Medicaid Enrolled • Provider Does Not Accept Client as a Medicaid Client	• Client Is Not Medicaid Enrolled
Service is covered by Medicaid	Provider can bill client **only** for cost sharing	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client
Service is not covered by Medicaid	Provider can bill client only if custom agreement has been made between client and provider before providing the service	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client

Routine Agreement: This may be a routine agreement between the provider and client which states that the client is not accepted as a Medicaid client, and that he or she must pay for the services received.

Custom Agreement: This agreement lists the service and date the client is receiving the service and states that the service is not covered by Medicaid and that the client will pay for it.

Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Cost sharing fees are a set dollar amount per visit, and they are based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. There is no cost sharing cap. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice. Cost sharing for dialysis services is $5.00 per visit.

Client cost sharing for dialysis services is $5.00 per visit.

The following clients are exempt from cost sharing:

- Clients under 21 years of age (i.e., EPSDT services)
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed)
- Inpatients in a hospital, skilled nursing facility, intermediate care facility or other medical institution if the individual is required to spend all but their personal needs allowance on the cost of care.
- Medicaid clients who also have Medicare or another insurance are exempt from cost sharing if the service is allowed by Medicare or paid by the other insurance, and Medicaid is the secondary payer.

Do not show cost sharing as a credit on the claim; it is automatically deducted.

Cost sharing may not be charged for the following services:

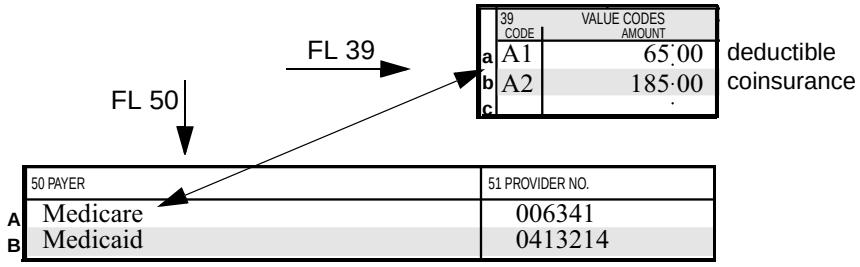
- Emergencies (see *Definitions*)
- Hospice
- Independent lab and x-ray services
- Personal assistance services
- Home dialysis attendant services
- Home and community based waiver services
- Non-emergency medical transportation services
- EPSDT services

A provider cannot deny services to a Medicaid client because the client cannot pay cost sharing fees at the time services are rendered. However, the client's inability to pay cost sharing fees when services are rendered does not lessen the client's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid clients, that same policy may be used for Medicaid clients.

Billing for Clients with Other Insurance

If a Medicaid client is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the client's health care, see the *Coordination of Benefits* chapter in this manual.

When completing a claim for clients with Medicare and Medicaid, Medicare coinsurance and deductible amounts listed in FL 39 must correspond with the payer listed in FL 50. For example, if the client has Medicare and Medicaid, any Medicare deductible and coinsurance amounts should be listed in FL 39 preceded by an A1, A2, etc. Because these amounts are for Medicare, Medicare should be listed in FL 50A (see the *Submitting a Claim* chapter in this manual).



Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the dialysis provider may:

- Accept the client as a Medicaid client from the current date.
- Accept the client as a Medicaid client from the date retroactive eligibility was effective.
- Require the client to continue as a private-pay client.

When the provider accepts the client's retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. Providers may need to contact the client's local office of public assistance (see the *General Information For Providers* manual, *Appendix B: Local Offices of Public Assistance*).

When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the service(s) before billing Medicaid for the service(s).

Coding

Always refer to the long descriptions in coding books.

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the table of *Coding Resources* on the following page. The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT-4, HCPCS Level II, and ICD-9-CM coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Take care to use the correct "units" measurement. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II billing manuals. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be "each 15 minutes". Always check the long text of the code description published in the CPT-4 or HCPCS Level II coding books.

Coding Resources

Please note that the Department does not endorse the products of any particular publisher.

Resource	Description	Contact
ICD-9-CM	• ICD-9-CM diagnosis and procedure codes definitions • Updated each October.	Available through various publishers and bookstores
CPT-4	• CPT-4 codes and definitions • Updated each January	American Medical Association (800) 621-8335 www.amapress.com or Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
HCPCS Level II	• HCPCS Level II codes and definitions • Updated each January and throughout the year	Available through various publishers and bookstores or from CMS at www.cms.gov
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 www.amapress.com
Miscellaneous resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 www.ntis.gov/product/correct-coding.htm
UB-92 National Uniform Billing Data Element Specifications	Montana UB-92 billing instructions	MHA - An Association of Montana Health Care Providers (formerly Montana Hospital Assoc.) Box 5119 Helena, MT 59604 406-442-1911 phone 406-443-3984 fax

Number of Lines on Claim

Providers are requested to put no more than 40 lines on a paper UB-92 claim. Although additional lines may be billed on the same claim, the Department claims processing system is most efficient for outpatient claims with 40 lines or fewer.

Multiple Services on Same Date

Dialysis providers must submit a single claim for all services provided to the same client on the same day. If services are repeated on the same day, use appropriate modifiers.

Span Bills

Dialysis providers may include services for more than one day on a single claim, so long as the date is shown on the claim.

Reporting Service Dates

- All line items must have a valid date of service in form locator (FL) 45.
- The following revenue codes require a separate line for each date of service and a valid CPT or HCPCS Level II code:

Revenue Codes That Require a Separate Line for Each Date of Service and a Valid CPT or HCPCS Code

26X	IV Therapy	51X	Clinic
28X	Oncology	52X	Free-Standing Clinic
30X	Laboratory	61X	Magnetic Resonance Imaging (MRI)
31X	Laboratory Pathological	63X	Drugs Requiring Specific Identification
32X	Radiology – Diagnostic	70X	Cast Room
33X	Radiology – Therapeutic	72X	Labor Room/Delivery
34X	Nuclear Medicine	73X	Electrocardiogram (EKG/ECG)
35X	Computed Tomographic (CT) Scan	74X	Electroencephalogram (EEG)
36X	Operating Room Services	75X	Gastro-Intestinal Services
38X	Blood	76X	Treatment or Observation Room
39X	Blood Storage and Processing	77X	Preventive Care Services
40X	Other Imaging Services	79X	Lithotripsy
41X	Respiratory Services	82X	Hemodialysis-Outpatient or Home
42X	Physical Therapy	83X	Peritoneal Dialysis-Outpatient or Home
43X	Occupational Therapy	84X	Continuous Ambulatory Peritoneal Dialysis (CAPD0-Out-patient
44X	Speech-Language Pathology	85X	Continuous Cycling Peritoneal Dialysis (CCPD)-Outpatient
45X	Emergency Department	88X	Miscellaneous Dialysis
46X	Pulmonary Function	90X	Psychiatric/Psychological Treatments
47X	Audiology	91X	Psychiatric/Psychological Services
48X	Cardiology	92X	Other Diagnostic Services
49X	Ambulatory Surgical Care	94X	Other Therapeutic Services

Using Modifiers

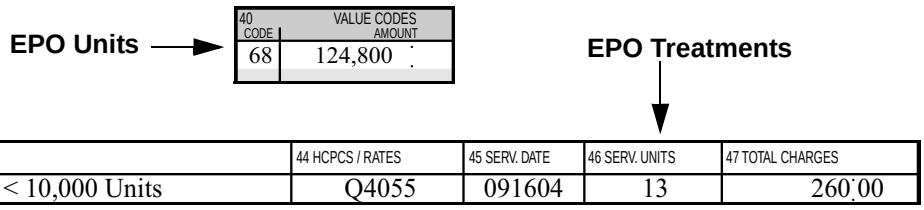
- Review the guidelines for using modifiers in the most current CPT-4 book, HCPCS Level II book, and other helpful resources (e.g., CPT Assistant, APC Answer Letter and others).
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- Medicaid accepts the same modifiers as Medicare.
- The Medicaid claims processing system recognizes only one modifier. The modifier must be added to the CPT/HCPCS code without a space or hyphen in form locator (FL) 44. For example, revenue code 821 with 90999 (hemodialysis composite with a URR reading of 75 or greater) is reported as FL42 = 821 and FL44 = 90999G5

The most important modifiers must be in the first position.

- Since the Medicaid claims processing system can read only one modifier per line, it is important to report the most important modifier first. In this case, the most important modifiers for Medicaid are those that affect pricing. Discontinued or reduced service modifiers must be listed before other pricing modifiers.

Billing for Epoetin (EPO)

When billing for EPO, FL 39-41 must be completed with a value code of 68 (EPO-Drug) and the number of EPO units as the amount, or the claim will deny. For example, a provider supplied a client with 13 treatments of EPO (< 10,000 units) during a month. The total units of EPO dispensed (124,800) should be reported as shown.



42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
634	Drug/EPO < 10,000 Units	Q4055	091604	13	260.00

Reference Lab Billing

Under federal regulations, all lab services must be billed to Medicaid by the lab that performed the service. Modifier 90, used to indicate reference lab services, is not covered by Medicaid.

Submitting a Claim

See the *Submitting a Claim* chapter in this manual for instructions on completing claims forms, submitting paper and electronic claims, and inquiring about a claim.

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a **7-digit** number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each paper claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, hand-written, or computer generated.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a UB-92 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client, verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual. Medicaid eligibility may change monthly.
Duplicate claim	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see *Remittance Advices and Adjustments* in this manual).
TPL on file and no credit amount on claim	• If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See *Coordination of Benefits* in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim.
Claim past 365-day filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Missing Medicare EOMB	All denied Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) with denial reason codes attached, and be billed to Medicaid on paper.
Type of service/procedure is not allowed for provider type	• Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual.
Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or provider number terminated	• Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expired licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Procedure is not allowed for provider type	• Provider is not allowed to perform the service. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the appropriate Medicaid fee schedule to verify the procedure code is valid for your provider type.
Value code 68 was not present on the claim	• When billing for EPO, FL 39-41 must contain a value code of 68 and the total number of EPO units.

Submitting a Claim

Electronic Claims

Institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact ACS EDI Gateway (see *Key Contacts*).
- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

Billing electronically with paper attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

9999999 - **888888888** - **11182003**

Medicaid Provider ID	Client ID Number	Date of Service (mmddyyyy)

The supporting documentation must be submitted with a paperwork attachment cover sheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Paper Claims

The services described in this manual are billed on UB-92 claim forms. Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the *Billing Procedure*s chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Client has Medicaid coverage only
- Client has Medicaid and Medicare coverage
- Client has Medicaid and third party liability coverage
- Client has Medicaid, Medicare, and third party liability coverage
- Client has Medicaid, Medicare, and Medicare supplement coverage

When completing a claim, remember the following:

- Please use this information together with the UB-92 Reference Manual.
- All form locators shown in this chapter are required or situational. Situational form locators are required if the information is applicable to the situation or client and are indicated by "**".
- Form locator 78 is used for cost sharing override codes (see following table and instructions in this chapter).

Cost Sharing Override Codes

E	Overrides cost sharing for emergency services
P	Overrides cost sharing for pregnant women

- Unless otherwise stated, all paper claims must be mailed to the following address:
  Claims Processing Unit
  P.O. Box 8000
  Helena, MT 59604

Claim Inquiries

Contact Provider Relations for questions regarding payments, denials, general claim questions, client eligibility, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A.* Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

Client Has Medicaid Coverage Only

FL	Form Locator Title	Instructions
1-2	Unlabeled fields	Provider name, complete mailing address, and phone number
3	Patient control number	The client's unique alphanumeric number assigned by the provider
4*	Type of bill	Enter the code indicating the type of bill (721 for FDC)
6*	Statement covers period	The beginning and ending service dates of the period included on this bill. These dates cannot be prior to the date the FDC was certified by CMS. Use MMDDYY format.
12	Patient name	Enter the Medicaid client's last name, first name and middle initial
13	Patient address	The client's mailing address including street name/P.O. box, city, state, and zip code
14	Patient birth date	The client's month, day, and year of birth (MMDDYYYY format)
15	Patient sex	Use M (male), F (female), or U (unknown)
17-20*	Admission	The admission date (MMDDYY format), hour, type, and source (see the UB-92 Reference Manual for specific codes)
22*	Patient status	A code indicating client status as of the ending service date of the period covered on this bill (see the UB-92 Reference Manual for specific codes)
39-41*	Value codes and amounts	When billing for EPO, include value code 68 and the number of EPO units dispensed.
42*	Revenue code	A code which identifies a specific accommodation, ancillary service or billing calculation (see the UB-92 Reference Manual for specific codes)
43	Description	Revenue code description (may abbreviate).
44**	HCPCS Rates	Enter the HCPCS or CPT code for each service that requires a code (see *Reporting Service Dates* in the *Billing Procedures* chapter of this manual).
45*	Service date	The date service was provided (MMDDYY format)
46*	Service units	A quantitative measure of services rendered by revenue category to or for the client. Must be appropriate for the procedure code.
47	Total charges	Total charges (covered and non-covered) for this line. If more than one line item appears on the claim, the total charge for all items are reported in this column as well.
50	Payer	Enter "Medicaid" when the client has Medicaid only coverage
51*	Provider number	Enter the provider's Medicaid ID number
54*	Prior payments	The amount the provider has received toward payment of this bill
58	Insured's name	Name of the individual in whose name the insurance is carried
60*	Cert - SSN - HIC - ID #	Client's Medicaid ID number
67-75*	Principal diagnosis code	Use the ICD-9-CM code for the principal diagnosis. Enter additional diagnoses codes in form locators 68-75
76*	Admitting diagnosis code	The ICD-9-CM code for the client's diagnosis or reason for visit
78	Unlabeled field	Enter applicable cost sharing override code (see *Override Codes* at the beginning of this chapter)
82*	Attending physician ID	For non-emergency outpatient services, enter the referring physician's Medicaid ID number.
85-86*	Provider representative signature and date	An authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications of the back of this bill. This date must be in MMDDYY format and must be on or after the last date of service reported in FL 6 of the claim.

* Required
** Required if applicable

Client Has Medicaid Coverage Only

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

The Dialysis Center
1212 Medical Drive
Anytown, MT 59999

1

2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
	12345678912	721

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
999999999	090104	093004					

12 PATIENT NAME	13 PATIENT ADDRESS
Spring, Rainy A.	12 Floweree Drive Anytown, MT 59999

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
02171935	F		090204	10	3	1		30			

	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a												A
b												B
												C

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	68	38,000				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	634	Drug/EPO < 10,000 Units	Q4055	090304	4	180 00		
2	636	Inj. Iron Sucrose, 1mg	J1756	092404	200	200 00		
3	636	Injection, paricalcitol, 1mcg	J2501	092404	60	2,220 00		
4	821	Hemo/composite	90999	092604	13	3,315 00		
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23						5,915 00		

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicaid	0999999					
B							
C							

57 **DUE FROM PATIENT ▶**

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Rainy A. Spring				
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68	69	70	71	72	73	74	75	76 ADM. DIAG. CD.	77 E-CODE	78
585									585		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
C		D		E	

82 ATTENDING PHYS. ID: 0009999 Smith, James P

	83 OTHER PHYS. ID	
a		A
b		

	OTHER PHYS. ID	
a		B
b		

	84 REMARKS
a	
b	
c	
d	

85 PROVIDER REPRESENTATIVE: X The Dialysis Center

86 DATE: 10/01/04

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Client Has Medicaid and Medicare Coverage

FL	Form Locator Title	Instructions
1-2	Unlabeled fields	Provider name, complete mailing address, and phone number
3	Patient control number	The client's unique alphanumeric number assigned by the provider
4*	Type of bill	Enter the code indicating the type of bill (721 for FDC).
6*	Statement covers period	The beginning and ending service dates of the period included on this bill. The dates cannot be prior to the date the FDC was certified by CMS. Use MMDDYY format.
12	Patient name	Enter the Medicaid client's last name, first name and middle initial
13	Patient address	The client's mailing address including street name/P.O. box, city, state, and zip code
14	Patient birth date	The client's month, day, and year of birth (MMDDYYYY format)
15	Patient sex	Enter M (male), F (female), or U (unknown)
17-20*	Admission	The admission date (MMDDYY format), hour, type, and source (see to the UB-92 Reference Manual for specific codes)
22*	Patient status	A code indicating client status as of the ending service date of the period covered on this bill (see the UB-92 Reference Manual for specific codes)
39-41*	Value codes and amounts	• Enter value codes A1, A2, A3, B1, B2, B3, etc. followed by the deductible and coinsurance amounts. These entries must corresponds with the entries in form locator 50 (A and B). See the *Billing Procedures* chapter, *Billing for clients with other insurance* section in this manual. • When billing for EPO, include value code 68 and the number of EPO units dispensed.
42*	Revenue code	A code which identifies a specific accommodation, ancillary service or billing calculation (see the UB-92 Reference Manual for specific codes)
43	Description	Revenue code description (may abbreviate).
44**	HCPCS Rates	Enter the HCPCS or CPT code for each service that requires a code (see *Reporting Service Dates* in the *Billing Procedures* chapter of this manual).
45	Service date	The date the indicated service was provided (MMDDYY format)
46*	Service units	A quantitative measure of services rendered by revenue category. Must be appropriate for the procedure code.
47	Total charges	Total charges (covered and non-covered) for this line.
50	Payer	The entries in this form locator correspond with the entries in form locators 39-41. Medicare should be listed first followed by Medicaid. See the *Billing Procedures* chapter, *Billing for clients with other insurance* section in this manual.
51*	Provider number	Enter the provider's Medicare and Medicaid ID numbers
54*	Prior payments	The amount the provider has received toward payment of this bill
58	Insured's name	Name of the individual in whose name the insurance is carried
60*	Cert - SSN - HIC - ID #	Client's Medicaid ID number
67-75*	Principal diagnosis code	Use the ICD-9-CM code for the principal diagnosis. Enter additional diagnosis codes in form locators 68-75
76*	Admitting diagnosis code	The ICD-9-CM code for the client's diagnosis or reason for visit
78	Unlabeled field	Enter applicable cost sharing override code (see *Override Codes* at the beginning of this chapter)
82*	Attending physician ID	For non-emergency outpatient services, enter the referring physician's Medicaid ID number. For emergency services, enter the emergency department physician's Medicaid ID number
85-86*	Provider representative signature and date	An authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications of the back of this bill. This date must be in MMDDYY format and must be on or after the last date of service reported in FL6 of this claim.

* Required
** Required if applicable

Client Has Medicaid and Medicare Coverage

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
The Dialysis Center 1212 Medical Drive Anytown, MT 59999		45604	721

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	090104	093004					

12 PATIENT NAME	13 PATIENT ADDRESS
Leaves, Autumn T.	45 Maple Lane Trees, MT 59999

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
03031922	F		090104	10	3	1		30									

	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37	
a												A	A
b												B	B
												C	C

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT	
a	A1	65.00	68	254,800			a
b	A2	185.00					b
c							c
d							d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	270	Medical/Surgical Supplies	A4657	090204	13	130.00			1
2	634	Drug/EPO < 10,000 Units	Q4055	091604	26	260.00			2
3	636	Inj. Doxercalciferol, 1mcg	J1270	092404	13	195.00			3
4	821	Hemo/Composite	90999	092604	13	1,950.00			4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23						$2,535.00			23

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	
A	Medicare	006341			1,878.00			A
B	Medicaid	0413214						B
C								C
	57	DUE FROM PATIENT ▶						

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.	
A	Leaves, Autumn T.		134537825			A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	
A					A
B					B
C					C

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
585									585		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
C		D		E	

82 ATTENDING PHYS. ID	
0006240	Dr. Patients

83 OTHER PHYS. ID		
	A	a b
OTHER PHYS. ID		
	B	a b

a b c d 84 REMARKS

85 PROVIDER REPRESENTATIVE	86 DATE
X The Dialysis Center	10/01/04

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Client Has Medicaid and Third Party Liability Coverage

FL	Form Locator Title	Instructions
1-2	Unlabeled fields	Provider name, complete mailing address, and phone number
3	Patient control number	The client's unique alphanumeric number assigned by the provider
4*	Type of bill	Enter the code indicating the type of bill (721 for FDC).
6*	Statement covers period	The beginning and ending service dates of the period included on this bill. The dates cannot be prior to the date the FDC was certified by CMS. Use MMDDYY format.
12	Patient name	Enter the Medicaid client's last name, first name and middle initial
13	Patient address	The client's mailing address including street name/P.O. box, city, state, and zip code
14	Patient birth date	The client's month, day, and year of birth (MMDDYYYY format)
15	Patient sex	Enter M (male), F (female), or U (unknown)
17-20*	Admission	The admission date (MMDDYY format), hour, type, and source (see to the UB-92 Reference Manual for specific codes)
22*	Patient status	A code indicating client status as of the ending service date of the period covered on this bill (see the UB-92 Reference Manual for specific codes)
39-41*	Value codes and amounts	• Enter value codes A1, A2, A3, B1, B2, B3, etc. followed by the deductible and coinsurance amounts. These entries must corresponds with the entries in form locator 50 (A and B). See the *Billing Procedures* chapter, *Billing for clients with other insurance* section in this manual. • When billing for EPO, include value code 68 and the number of EPO units dispensed.
42*	Revenue code	A code which identifies a specific accommodation, ancillary service or billing calculation (see the UB-92 Reference Manual for specific codes)
43	Description	Revenue code description (may abbreviate).
44**	HCPCS Rates	Enter the HCPCS or CPT code for each service that requires a code (see *Reporting Service Dates* in the *Billing Procedures* chapter of this manual).
45	Service date	The date the indicated service was provided (MMDDYY format)
46*	Service units	A quantitative measure of services rendered by revenue category. Must be appropriate for the procedure code.
47	Total charges	Total charges (covered and non-covered) for this line.
50	Payer	The entries in this form locator correspond with the entries in form locators 39-41. Medicare should be listed first followed by Medicaid. See the *Billing Procedures* chapter, *Billing for clients with other insurance* section in this manual.
51*	Provider number	Enter the provider's Medicare and Medicaid ID numbers
54*	Prior payments	The amount the provider has received toward payment of this bill
58	Insured's name	Name of the individual in whose name the insurance is carried
60*	Cert - SSN - HIC - ID #	Client's Medicaid ID number
67-75*	Principal diagnosis code	Use the ICD-9-CM code for the principal diagnosis. Enter additional diagnosis codes in form locators 68-75
76*	Admitting diagnosis code	The ICD-9-CM code for the client's diagnosis or reason for visit
78	Unlabeled field	Enter applicable cost sharing override code (see *Override Codes* at the beginning of this chapter)
82*	Attending physician ID	For non-emergency outpatient services, enter the referring physician's Medicaid ID number. For emergency services, enter the emergency department physician's Medicaid ID number
85-86*	Provider representative signature and date	An authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications of the back of this bill. This date must be in MMDDYY format and must be on or after the last date of service reported in FL6 of this claim.

* Required
** Required if applicable

Client Has Medicaid and Third Party Liability Coverage

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1 The Dialysis Clinic
1212 Medical Drive
Anytown, MT 59999

2

3 PATIENT CONTROL NO.: 4806

4 TYPE OF BILL: 721

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD: FROM 09/01/04 THROUGH 09/30/04

7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: Flower, Lilly T.

13 PATIENT ADDRESS: 33 Flower Lane Buds, MT 59000

14 BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
03261980	F		09/01/04	10	3	1		01									

ADMISSION: 17 DATE, 18 HR, 19 TYPE, 20 SRC

32 OCCURRENCE CODE / DATE | 33 OCCURRENCE CODE / DATE | 34 OCCURRENCE CODE / DATE | 35 OCCURRENCE CODE / DATE | 36 OCCURRENCE SPAN CODE / FROM / THROUGH | 37 A B C

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	A1	25.00	68	235,200.		
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	270	Medical/Surgical Supplies	A4657	090204	13	130.00		
2	634	Drug/EPO < 10,000 Units	Q4055	091304	4	40.00		
3	634	Drug/EPO < 10,000 Units	Q4055	091604	4	40.00		
4	634	Drug/EPO < 10,000 Units	Q4055	091804	4	40.00		
5	634	Drug/EPO < 10,000 Units	Q4055	092004	4	40.00		
6	634	Drug/EPO < 10,000 Units	Q4055	092304	8	80.00		
7	821	Hemo/Composite	90999	090104	1	150.00		
8	821	Hemo/Composite	90999	090304	1	150.00		
9	821	Hemo/Composite	90999	090504	1	150.00		
10	821	Hemo/Composite	90999	090804	1	150.00		
11	821	Hemo/Composite	90999	091104	1	150.00		
12	821	Hemo/Composite	90999	091304	1	150.00		
13	821	Hemo/Composite	90999	091504	1	150.00		
14	821	Hemo/Composite	90999	091804	1	150.00		
15	821	Hemo/Composite	90999	092004	1	150.00		
16	821	Hemo/Composite	90999	092204	1	150.00		
17	821	Hemo/Composite	90999	092404	1	150.00		
18	821	Hemo/Composite	90999	092704	1	150.00		
19	821	Hemo/Composite	90999	092904	1	150.00		
20								
21								
22								
23						2,200.00		

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Double Indemnity Insurance	340367			1752.00		
B	Medicaid	0413213					
C							

57 **DUE FROM PATIENT ▶**

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Flower, Bud		432701763		
B	Flower, Lilly		134638752		
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A	3073164721			
B				
C				

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
585									585		

OTHER DIAG. CODES: 68–75

79 P.C. | 80 PRINCIPAL PROCEDURE CODE / DATE | 81 OTHER PROCEDURE CODE / DATE (A) | OTHER PROCEDURE CODE / DATE (B)

OTHER PROCEDURE CODE / DATE (C) | OTHER PROCEDURE CODE / DATE (D) | OTHER PROCEDURE CODE / DATE (E)

82 ATTENDING PHYS. ID: E06674 Dr. Thorne

83 OTHER PHYS. ID (A) a b

OTHER PHYS. ID (B) a b

84 REMARKS a b c d

85 PROVIDER REPRESENTATIVE: X The Dialysis Center

86 DATE: 10/01/04

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Client Has Medicaid, Medicare, and Third Party Liability Coverage

FL	Form Locator Title	Instructions
1-2	Unlabeled fields	Provider name, complete mailing address, and phone number
3	Patient control number	The client's unique alphanumeric number assigned by the provider
4*	Type of bill	Enter the code indicating the type of bill (721 for FDC).
6*	Statement covers period	The beginning and ending service dates of the period included on this bill. The dates cannot be prior to the date the FDC was certified by CMS. Use MMDDYY format.
12	Patient name	Enter the Medicaid client's last name, first name and middle initial
13	Patient address	The client's mailing address including street name/P.O. box, city, state, and zip code
14	Patient birth date	The client's month, day, and year of birth (MMDDYYYY format)
15	Patient sex	Enter M (male), F (female), or U (unknown)
17-20*	Admission	The admission date (MMDDYY format), hour, type, and source (see to the UB-92 Reference Manual for specific codes)
22*	Patient status	A code indicating client status as of the ending service date of the period covered on this bill (see the UB-92 Reference Manual for specific codes)
39-41*	Value codes and amounts	• Enter value codes A1, A2, A3, B1, B2, B3, etc. followed by the deductible and coinsurance amounts. These entries must corresponds with the entries in form locator 50 (A and B). See the *Billing Procedures* chapter, *Billing for clients with other insurance* section in this manual. • When billing for EPO, include value code 68 and the number of EPO units dispensed.
42*	Revenue code	A code which identifies a specific accommodation, ancillary service or billing calculation (see the UB-92 Reference Manual for specific codes)
43	Description	Revenue code description (may abbreviate).
44**	HCPCS Rates	Enter the HCPCS or CPT code for each service that requires a code (see *Reporting Service Dates* in the *Billing Procedures* chapter of this manual).
45	Service date	The date the indicated service was provided (MMDDYY format)
46*	Service units	A quantitative measure of services rendered by revenue category. Must be appropriate for the procedure code.
47	Total charges	Total charges (covered and non-covered) for this line.
50	Payer	The entries in this form locator correspond with the entries in form locators 39-41. Medicare should be listed first followed by Medicaid. See the *Billing Procedures* chapter, *Billing for clients with other insurance* section in this manual.
51*	Provider number	Enter the provider's Medicare and Medicaid ID numbers
54*	Prior payments	The amount the provider has received toward payment of this bill
58	Insured's name	Name of the individual in whose name the insurance is carried
60*	Cert - SSN - HIC - ID #	Client's Medicaid ID number
67-75*	Principal diagnosis code	Use the ICD-9-CM code for the principal diagnosis. Enter additional diagnosis codes in form locators 68-75
76*	Admitting diagnosis code	The ICD-9-CM code for the client's diagnosis or reason for visit
78	Unlabeled field	Enter applicable cost sharing override code (see *Override Codes* at the beginning of this chapter)
82*	Attending physician ID	For non-emergency outpatient services, enter the referring physician's Medicaid ID number. For emergency services, enter the emergency department physician's Medicaid ID number
85-86*	Provider representative signature and date	An authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications of the back of this bill. This date must be in MMDDYY format and must be on or after the last date of service reported in FL6 of this claim.

* Required
** Required if applicable

Client Has Medicaid, Medicare, and Third Party Liability Coverage

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
The Dialysis Clinic 1212 Medical Drive Anytown, MT 59999		4806	721

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	09/01/04	09/30/04					

12 PATIENT NAME	13 PATIENT ADDRESS
Lion, Dandi	4854 Animal Creek Lane Weeds, MT 59999

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
06/01/23	M		09/01/04	10	3	1		30									

	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37	
a												A	A
b												B	B
												C	C

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT	
a	A1	100.00	68	465,600.			a
b	A2	15.00					b
c							c
d							d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	270	Medical/Surgical Supplies	A4657	091504	1	10.00			1
2	634	Drug/EPO < 10,000 Units	Q4055	090304	4	40.00			2
3	634	Drug/EPO < 10,000 Units	Q4055	090804	4	40.00			3
4	634	Drug/EPO < 10,000 Units	Q4055	091004	4	40.00			4
5	634	Drug/EPO < 10,000 Units	Q4055	091304	6	60.00			5
6	634	Drug/EPO < 10,000 Units	Q4055	091504	6	60.00			6
7	634	Drug/EPO < 10,000 Units	Q4055	092004	6	60.00			7
8	634	Drug/EPO < 10,000 Units	Q4055	092204	6	60.00			8
9	634	Drug/EPO < 10,000 Units	Q4055	092404	6	60.00			9
10	634	Drug/EPO < 10,000 Units	Q4055	093004	6	60.00			10
11	636	Inj. HepB	90747	091304	1	200.00			11
12	636	Inj. Iron Sucrose 1mg	J1756	091504	100	100.00			12
13	821	Hemo/Composite	90999	090304	1	200.00			13
14	821	Hemo/Composite	90999	090804	1	200.00			14
15	821	Hemo/Composite	90999	091004	1	200.00			15
16	821	Hemo/Composite	90999	091304	1	200.00			16
17	821	Hemo/Composite	90999	091504	1	200.00			17
18	821	Hemo/Composite	90999	092004	1	200.00			18
19	821	Hemo/Composite	90999	092204	1	200.00			19
20	821	Hemo/Composite	90999	092404	1	200.00			20
21	821	Hemo/Composite	90999	093004	1	200.00			21
22									22
23						2,590.00			23

The payers in FL 50 must correspond with the payment(s) in FL 39.

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	
A	Medicare	01111134			1,872.00			A
B	Double Indemnity Ins.	340367			200.00			B
C	Medicaid	0413213						C
57		DUE FROM PATIENT ▶						

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.	
A	Lion, Dandi		123776601			A
B	Lion, Dandi		123776601DII			B
C	Lion, Dandi		123776601			C

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	
A	3073164723				A
B					B
C					C

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
585									585		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	C		D		E	

	84 REMARKS
a	
b	
c	
d	

82 ATTENDING PHYS. ID	
0043251	Dr. Ashton

83 OTHER PHYS. ID		
A		a
		b
OTHER PHYS. ID		a
B		b

85 PROVIDER REPRESENTATIVE	86 DATE
X The Dialysis Center	10/01/04

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

FL	Form Locator Title	Instructions
1-2	Unlabeled fields	Provider name, complete mailing address, and phone number
3	Patient control number	The client's unique alphanumeric number assigned by the provider
4*	Type of bill	Enter the code indicating the type of bill (721 for FDC).
6*	Statement covers period	The beginning and ending service dates of the period included on this bill. The dates cannot be prior to the date the FDC was certified by CMS. Use MMDDYY format.
12	Patient name	Enter the Medicaid client's last name, first name and middle initial
13	Patient address	The client's mailing address including street name/P.O. box, city, state, and zip code
14	Patient birth date	The client's month, day, and year of birth (MMDDYYYY format)
15	Patient sex	Enter M (male), F (female), or U (unknown)
17-20*	Admission	The admission date (MMDDYY format), hour, type, and source (see to the UB-92 Reference Manual for specific codes)
22*	Patient status	A code indicating client status as of the ending service date of the period covered on this bill (see the UB-92 Reference Manual for specific codes)
39-41*	Value codes and amounts	• Enter value codes A1, A2, A3, B1, B2, B3, etc. followed by the deductible and coinsurance amounts. These entries must corresponds with the entries in form locator 50 (A and B). See the *Billing Procedures* chapter, *Billing for clients with other insurance* section in this manual. • When billing for EPO, include value code 68 and the number of EPO units dispensed.
42*	Revenue code	A code which identifies a specific accommodation, ancillary service or billing calculation (see the UB-92 Reference Manual for specific codes)
43	Description	Revenue code description (may abbreviate).
44**	HCPCS Rates	Enter the HCPCS or CPT code for each service that requires a code (see *Reporting Service Dates* in the *Billing Procedures* chapter of this manual).
45	Service date	The date the indicated service was provided (MMDDYY format)
46*	Service units	A quantitative measure of services rendered by revenue category. Must be appropriate for the procedure code.
47	Total charges	Total charges (covered and non-covered) for this line.
50	Payer	The entries in this form locator correspond with the entries in form locators 39-41. Medicare should be listed first followed by Medicaid. See the *Billing Procedures* chapter, *Billing for clients with other insurance* section in this manual.
51*	Provider number	Enter the provider's Medicare and Medicaid ID numbers
54*	Prior payments	The amount the provider has received toward payment of this bill
58	Insured's name	Name of the individual in whose name the insurance is carried
60*	Cert - SSN - HIC - ID #	Client's Medicaid ID number
67-75*	Principal diagnosis code	Use the ICD-9-CM code for the principal diagnosis. Enter additional diagnosis codes in form locators 68-75
76*	Admitting diagnosis code	The ICD-9-CM code for the client's diagnosis or reason for visit
78	Unlabeled field	Enter applicable cost sharing override code (see *Override Codes* at the beginning of this chapter)
82*	Attending physician ID	For non-emergency outpatient services, enter the referring physician's Medicaid ID number. For emergency services, enter the emergency department physician's Medicaid ID number
85-86*	Provider representative signature and date	An authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications of the back of this bill. This date must be in MMDDYY format and must be on or after the last date of service reported in FL6 of this claim.

* Required
** Required if applicable

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

The Dialysis Clinic 1212 Medical Drive Anytown, MT 59999	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL 721	
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 09/01/04 THROUGH 09/30/04	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11

12 PATIENT NAME	13 PATIENT ADDRESS	
Terry, Clark	854 Standing Rock Rd.	Open Range, MT 59409

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
06/14/32	M		00/01/04	10	3	1		30									

	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37
a												A
b												B
												C

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	A2	130.32	68	1,146,600.		
b		.		.		.
c		.		.		.
d		.		.		.

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	270	Medical/Surgical Supplies	A4657	090704	7	70.00	.		1
2	634	Drug/EPO < 10,000 Units	Q4055	090204	117	1,170.00	.		2
3	636	Inj. Iron Sucrose, 1mg	J1756	090704	700	700.00	.		3
4	821	Hemo/Composite	90999	093004	13	2,600.00	.		4
5						.	.		5
6						.	.		6
7						.	.		7
8						.	.		8
9						.	.		9
10						.	.		10
11						.	.		11
12						.	.		12
13						.	.		13
14						.	.		14
15						.	.		15
16						.	.		16
17						.	.		17
18						.	.		18
19						.	.		19
20						.	.		20
21						.	.		21
22						.	.		22
23						4,540.00	.		23

The payers in FL 50 must correspond with the payment(s) in FL 39.

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicare	340367			343.00	.	
B	AARP	540767			150.00	.	
C	Medicaid	041324			.	.	
57		**DUE FROM PATIENT ▶**			.	.	

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Terry, Clark		135454054A		
B	Terry, Clark		135454054AP		
C	Terry, Clark		135454054		

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68	69	70	71	72	73	74	75	76 ADM. DIAG. CD.	77 E-CODE	78
585									585		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	C		D		E	

82 ATTENDING PHYS. ID: 0016703 Dr. Sparks

	83 OTHER PHYS. ID	
a		A
b		
a	OTHER PHYS. ID	B
b		

	84 REMARKS
a	
b	
c	
d	

85 PROVIDER REPRESENTATIVE: X The Dialysis Center

86 DATE: 10/01/04

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 Agreement

Your signature on the UB-92 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.

5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required be Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.
   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

Avoiding Claim Errors

Claims are often denied or even returned to the provider before they can be processed. To avoid denials and returns, double check each claim form to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

Common Claim Errors

Claim Error	Prevention
Required form locator is blank	Check the claim instructions earlier in this chapter for required form locators. If a required form locator is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required form locator (FL 60); verify that the client's Medicaid ID number is listed as it appears on the client's eligibility verification (see the *General Information For Providers, Client Eligibility* chapter).
Client name missing	This is a required form locator (FL 12); check that it is correct.
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim (FL 51).
Not enough information regarding other coverage	Form locators 39-41, 50, and in some cases 54, are required when a client has other coverage (refer to the examples earlier in this chapter).
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a UB-92 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.

MONTANA
Department of Public Health & Human Services

Remittance Advices and Adjustments

The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Electronic RA

Providers may receive the RA electronically as an ANSI ASC X12N 835 transaction, or through the Internet on the Montana Eligibility and Payment System (MEPS). For more information on X12N 835 transactions, see the Companion Guides available on the ACS EDI Gateway website and the Implementation Guides on the Washington Publishing Company website (see *Key Contacts*).

Electronic RAs are available for only six weeks on MEPS.

MEPS is available through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form* (see *Payment and the RA* within this chapter). After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

If a claim was denied, read the description of the reason and remark code before taking any action on the claim.

RAs are available from MEPS in PDF and a flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the "SOR Download" page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks. For more information on MEPS, see *Payment and the RA* later in this chapter.

Paper RA

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.

The pending claims section of the RA is informational only. Do not take any action on the claims shown here.

Sections of the Paper RA

Section	Description
RA notice	The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.
Paid claims	This section shows claims paid and any claims paid with denied lines during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter).
Denied claims	This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter.
Pending claims	All claims that have not reached final disposition will appear in this area of the RA. The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/ Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied. Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.
Credit balance claims	Credit balance claims are shown here until the credit has been satisfied.
Gross adjustments	Any gross adjustments performed during the previous cycle are shown here.
Reason and remark code description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604
REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP (1)

THE DIALYSIS CENTER
1212 MEDICAL DRIVE
ANYTOWN MT 59999

(2) PROVIDER# 0001234567 (3) REMIT ADVICE #123456 (4) WARRANT # 654321 (5) DATE:10/05/04 PAGE 2 (6)

RECIP ID (7)	NAME (8)	SERVICE DATES FROM	TO (10)	UNIT OF SVC (11)	PROCEDURE REVENUE NDC (12)	TOTAL CHARGES (13)	ALLOWED (14)	CO-PAY (15)	REASON/ REMARK CODES (16)
PAID CLAIMS - MISCELLANEOUS CLAIMS									
123456789 (9)	DOE, JOHN EDWARD	090104	093004	14	634	314.60	140.00	N	
ICN	00427911350000700			13	821	3263.00	1691.04		
		LESS MEDICARE PAID*******					1500.00		
		CLAIM TOTAL*******				3577.60	(17)		
DENIED CLAIMS - MISCELLANEOUS CLAIMS									
123456790	DOE, JANE EDWINA	090104	093004	14 (16)	634	5953.20	0.00	Y	
ICN	00204011350000800	090104	093004	14 (16)	821	3514.00	0.00 (17)	Y	
		CLAIM TOTAL*******				9467.20			31 MA61
PENDING CLAIMS - MISCELLANEOUS CLAIMS									
123456791	DOE, JERRY ERIC	090104	093004	2	821	502.00	0.00 (17)	N	31
ICN	00204011350000900								
		CLAIM TOTAL*******				502.00			

**********THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE**********

31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Key Fields on the Remittance Advice

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider by Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information: 0 00111 11 123 000123 A B C D E A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or point-of-sale (POS) pharmacy claim) B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)
10. Service dates	Date(s) services were provided. If service(s) were performed in a single day, the same date will appear in both columns
11. Unit of service	The units of service rendered under this procedure, NDC code or revenue code.
12. Procedure/revenue/NDC	The procedure code (CPT, HCPCS, or local), National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Copay	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
16. Reason/Remark code	A code which explains why the service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Credit balance claims

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

1. By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

The credit balance section is informational only. Do not post from credit balance statements.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or requesting Provider Relations (see *Credit balances* #2 above) to complete a gross adjustment.

Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in *Billing Procedures* chapter).

Rebilling Medicaid

Rebilling is when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* and *Submitting a Claim* chapters.

Rebill denied claims only after appropriate corrections have been made.

When to rebill Medicaid

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the reason and remark code,

make the appropriate corrections, and resubmit the claim on a UB-92 form (not the adjustment form).

- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to rebill

- Check any reason and remark code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information.
- Enter any insurance (TPL) information on the corrected claim, or attach insurance denial information to the corrected claim, and send it to Claims Processing (see *Key Contacts*).

Adjustments

Adjustments can only be made to paid claims.

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see *Appendix A: Forms*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit will be a 2, indicating an adjustment. See *Key Fields on the Remittance Advice* earlier in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).
- Request an adjustment when a single line on a multi-line claim was denied. The denied service must be submitted as an adjustment rather than a rebill.

How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix A.* The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section of the adjustment form.

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A.* You may also order forms from Provider Relations or download them from the Provider Information website (see *Key Contacts*). Complete Section A first with provider and client information and the claim's ICN number (see following table and sample RA).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
   - Enter the date of service or the line number in the *Date of Service or Line Number* column.
   - Enter the information from the claim form that was incorrect in the *Information on Statement* column.
   - Enter the correct information in the column labeled *Corrected Information*.

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Recipient name	The client's name is here.
3.* Internal control number (ICN)	There can be only one ICN per adjustment request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider number	The provider's Medicaid ID number.
5.* Recipient Medicaid number	Client's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice field #5 (see the sample RA earlier in this chapter).
7. Amount of payment	The amount of payment from the remittance advice field #17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/ NDC/ Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (Nursing facility)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

3. Attach copies of the RA and a corrected claim if necessary.
   - If the original claim was billed electronically, a copy of the RA will suffice.
   - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit. If the result is a credit balance, it can be worked off or the provider can pay off the balance by check (see *Credit balances* earlier in this chapter).
- Any questions regarding claims or adjustments must be directed to Provider Relations (see *Key Contacts*).

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:
This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS
The Dialysis Center
Name
1212 Medical Drive
Street or P.O. Box
Anytown, MT 59999
City State Zip

3. INTERNAL CONTROL NUMBER (ICN): 00404011250000600
4. PROVIDER NUMBER: 1234567
5. CLIENT ID NUMBER: 123456789
2. CLIENT NAME: Jane Doe
6. DATE OF PAYMENT: 10/01/04
7. AMOUNT OF PAYMENT $: 180.00

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service	Line 2	2	1
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)	Line 3	09/01/04	09/15/04
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: Betty Biller. DATE: 10/15/04

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Sample Adjustment Request

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section). Mass adjustment claims shown on the RA have an ICN that begins with a "4" (see *Key Fields on the Remittance Advice* earlier in this chapter).

Payment and The RA

Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

Electronic Funds Transfer

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. To arrange for EFT, call the number listed under *Direct Deposit Arrangements* in *Key Contacts*.

Electronic Remittance Advice

To receive an electronic RA, the provider must be enrolled in electronic funds transfer and have internet access. You can access your electronic RA through the Montana Eligibility and Payment System (MEPS) on the internet through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form* (see the following table).

Electronic RAs are available for only six weeks on MEPS.

After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

RAs are available from MEPS in PDF and a flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the "SOR Download" page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks.

Required Forms For EFT and/or Electronic RA

All three forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form)	• Provider Information website • Provider Relations (see *Key Contacts*)	Provider Relations (see *Key Contacts*)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider Information website (see *Key Contacts*) • Provider's bank	Provider Relations (see *Key Contacts*)
MEPS Access Request Form	Allows provider to receive a password to access their RA on MEPS	• Provider Information website • Virtual Human Services Pavilion • Direct Deposit Arrangements (see *Key Contacts)*	DPHHS address on the form

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

Dialysis Center Rates

The Centers for Medicare and Medicaid (CMS) establishes rates for each facility. Rates are dependent in part on whether the facility is hospital based or independent. CMS updates dialysis care rates periodically, usually in January. They issue a list of rates applicable to specific facilities in Montana. Medicaid applies these rates for services supplied to Montana Medicaid recipients. The following table is an example of dialysis rates for Montana as of October, 2004 and may not apply to all facilities in Montana and at other times.

Dialysis Rates Three Times a Week as of October 1, 2004

Service	Base Rate	Non-Labor Share	Labor Share	Area Wage Index	Labor share, Indexed	Total
Dialysis-hospital based facility	$ 130.32	$82.39	$47.93	0.9	$43.14	$ 125.53
Dialysis- independent facility	$ 126.33	$74.98	$51.35	0.9	$46.22	$ 121.20

Exception to indexed rates

Facilities can apply for and receive an exception from the standard dialysis rate from Medicare. If Medicare grants an exception, the facility will receive a letter from Medicare stating the applicable rates for dialysis services. Montana Medicaid will honor these exception letters, which are generally valid for one year. It is the responsibility of the facility to get a copy of the exception letter to Montana Medicaid. If there is no current exception letter on file, it is assumed that the standard, indexed rate for the facility applies.

Calculating payment

Providers can estimate the payment received by Medicaid using the following method. In this example, a dialysis unit provides a client with dialysis three times in one week, including 40 units of Epoetin. To calculate the payment the dialysis facility will receive for this client, multiply the units by the rate for each category of service and total the amounts for a payment of $1,576.59, less any applicable fees (e.g., incurment, etc.).

Sample Payment Calculation for Dialysis Client
Three times per week

Date of Service	Revenue Code	Service	Units	Payment Rate	Total
10-1-2004	821	90999 Dialysis Procedure	1	$125.53	$125.53
10-3-2004	821	90999 Dialysis Procedure	1	$125.53	$125.53
10-5-2004	821	90999 Dialysis Procedure	1	$125.53	$125.53
10-1-2004	634	Q4055 Epoetin	40	$10.00	$400.00
10-3-2004	634	Q4055 Epoetin	40	$10.00	$400.00
10-5-2004	634	Q4055 Epoetin	40	$10.00	$400.00
					$1,576.59

The payment rate for daily dialysis is a fraction of the rate for dialysis treatments three times per week. The following example shows the calculation for the same provider, above, if dialysis treatments are done daily. Note that the only difference in total reimbursement is the additional cost of Epoetin for the additional daily treatments.

Sample Payment Calculation for Dialysis Client Daily Treatments

Date of Service	Revenue Code	Service	Units	Payment Rate	Total
10-1-2004	841	90999 Dialysis Procedure	1	$53.80	$53.80
10-2-2004	841	90999 Dialysis Procedure	1	$53.80	$53.80
10-3-2004	841	90999 Dialysis Procedure	1	$53.80	$53.80
10-4-2004	841	90999 Dialysis Procedure	1	$53.80	$53.80
10-5-2004	841	90999 Dialysis Procedure	1	$53.80	$53.80
10-6-2004	841	90999 Dialysis Procedure	1	$53.80	$53.80
10-7-2004	841	90999 Dialysis Procedure	1	$53.80	$53.80
10-1-2004	634	Q4055 Epoetin	40	$10.00	$400.00
10-2-2004	634	Q4055 Epoetin	40	$10.00	$400.00
10-3-2004	634	Q4055 Epoetin	40	$10.00	$400.00
10-4-2004	634	Q4055 Epoetin	40	$10.00	$400.00
10-5-2004	634	Q4055 Epoetin	40	$10.00	$400.00
10-6-2004	634	Q4055 Epoetin	40	$10.00	$400.00
10-7-2004	634	Q4055 Epoetin	40	$10.00	$400.00
					$3,176.60

How payment is calculated on TPL claims

When a client has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as Third Party Liability or TPL. In these cases, the other insurance is the primary payer (as described in the *Coordination of Benefits* chapter of this manual), and Medicaid makes a payment as the secondary payer. Medicaid will make a payment only when the TPL payment is less than the Medicaid allowed amount.

How payment is calculated on Medicare crossover claims

When a client has coverage from both Medicare and Medicaid, Medicare is the primary payer. Medicaid will pay the coinsurance and deductible, less any TPL or incurment, on dialysis claims for these dually eligible individuals.

Payment examples for dually eligible clients

Client has Medicare and Medicaid coverage. A provider submits a dialysis claim for a client with Medicare and Medicaid. The Medicare coinsurance and deductible are $65.00 and $185.00. This total ($250.00) becomes the Medicaid allowed amount. Medicaid will pay this amount ($250.00) as long as no TPL or incurment amounts are applicable.

Client has Medicare, Medicaid, and TPL. A provider submits a dialysis claim for a client with Medicare, Medicaid, and TPL. The Medicare coinsurance and deductible are $65.00 and $185.00. This total ($250.00) becomes the Medicaid allowed amount. The other insurance company paid $225.00. This amount is subtracted from the Medicaid allowed amount leaving $25.00. Medicaid pays $25.00 for this claim. If the TPL payment had been $250.00 or more, this claim would have paid at $0.00.

Client has Medicare, Medicaid, and Medicaid Incurment. A provider submits a dialysis claim for a client with Medicare, Medicaid, and a Medicaid incurment. The Medicare coinsurance and deductible are $65.00 and $185.00. This total ($250.00) becomes the Medicaid allowed amount. The client owes $150 for his Medicaid incurment, so this amount is subtracted from the $250.00. Medicaid will pay the provider $100.00 for this claim.

Appendix A: Forms

- ***Montana Medicaid/MHSP/CHIP Individual Adjustment Request***
- ***Montana Medicaid Claim Inquiry Form***
- ***Paperwork Attachment Cover Sheet***

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

_____
Name

_____
Street or P.O. Box

_____
City **State** **Zip**

2. CLIENT NAME

_____

3. INTERNAL CONTROL NUMBER (ICN)

_____

4. PROVIDER NUMBER

_____

5. CLIENT ID NUMBER

_____

6. DATE OF PAYMENT _____

7. AMOUNT OF PAYMENT $ _____

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Montana Medicaid Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____

For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Provider number _____	ACS Response: _____
Client number _____	
Date of service _____	
Total billed amount _____	
Date submitted for processing _____	
Provider number _____	ACS Response: _____
Client number _____	
Date of service _____	
Total billed amount _____	
Date submitted for processing _____	
Provider number _____	ACS Response: _____
Client number _____	
Date of service _____	
Total billed amount _____	
Date submitted for processing _____	

Mail to: Provider Relations
P.O. Box 8000
Helena, MT 59604

Fax to: (406) 442-4402

MONTANA
Department of Public Health & Human Services

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: _____

Date of service: _____

Medicaid provider number: _____

Medicaid client ID number: _____

Type of attachment: _____

Instructions:

This form is used as a cover sheet for attachments to electronic claims sent to Montana Medicaid. The *Paperwork Attachment Control Number* must be the same number as the *Attachment Control Number* on the corresponding electronic claim. This number should consist of the provider's Medicaid ID number, the client's Medicaid ID number and the date of service (mmddyyyy), each separated by a dash (9999999-999999999-99999999). This form may be copied or downloaded from our website www.mtmedicaid.org. If you have questions about which paper attachments are necessary for a claim to process, please call Provider Relations at (406) 442-1837 or (800) 624-3958.

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Allowed Amount
The maximum amount reimbursed to a provider for a health care service as determined by Medicaid or another payer. Other cost factors, (such as cost sharing, TPL, or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Ancillary Provider
Any provider that is subordinate to the client's primary provider, or providing services in the facility or institution that has accepted the client as a Medicaid client.

Assignment of Benefits
A voluntary decision by the client to have insurance benefits paid directly to the provider rather than to the client. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Authorization
An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid
Patients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Bundled
Items or services that are deemed integral to performing a procedure or visit are not paid separately in the APC system. They are packaged (also called bundled) into the payment for the procedure or visit. Medicare developed the relative weights for surgical, medical and other types of visits so that the weights reflect the packaging rules used in the APC method. Items or services that are packaged receive a status code of "N".

Cash Option
Cash option allows the client to pay a monthly premium to Medicaid and have Medicaid coverage for the entire month rather than a partial month.

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Children's Health Insurance Plan (CHIP)
This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by BlueCross BlueShield of Montana.

Clean Claim
A claim that can be processed without additional information from or action by the provider of the service.

Client
An individual enrolled in a Department medical assistance program.

Code of Federal Regulations (CFR)
Rules published by executive departments and agencies of the federal government.

Coinsurance
The client's financial responsibility for a medical bill as assigned Medicare (usually a percentage). Medicare coinsurance is usually 20% of the Medicare allowed amount.

Conversion Factor
A state specific dollar amount that converts relative values into an actual fee. This calculation allows each payer to adopt the RBRVS to its own economy.

Copayment
The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic
Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost Sharing
The client's financial responsibility for a medical bill assessed by flat fee or percentage of charges.

Crossovers
Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles
Clients who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Emergency Services
A service is reimbursed as an emergency if one of the following criteria is met:

- The service is billed with a CPT code of 99284 or 99285
- The client has a qualifying emergency diagnosis code. A list of emergency diagnosis codes is available on the Provider Information website.
- The services did not meet one of the previous two requirements, but the hospital believes an emergency existed. In this case, the claim and documentation supporting the emergent nature of the service must be mailed to the emergency department review contractor (see *Key Contacts*).

Experimental
A non-covered item or service that researchers are studying to investigate how it affects health.

Fiscal Agent
ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Dialysis Clinic
Dialysis clinics are clinics that provide dialysis services to clients suffering from end stage renal disease (ESRD).

Full Medicaid
Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment
A lump sum debit or credit that is not claim specific made to a provider.

Home Dialysis
Dialysis performed by an appropriately trained patient at home.

Indian Health Service (IHS)
IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment
A request for a correction to a specific paid claim.

Investigational
A non-covered item or service that researchers are studying to investigate how it affects health.

Kiosk
A "room" or area in the Montana Virtual Human Services Pavilion (VHSP) website that contains information on the topic specified.

Mass Adjustment
Request for a correction to a group of claims meeting specific defined criteria.

Medicaid
A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medicaid Eligibility and Payment System (MEPS)
A computer system by which providers may access a client's eligibility, demographic, and claim status history information via the internet.

Medically Necessary
A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare
The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)
This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

Mutually Exclusive Code Pairs
These codes represent services or procedures that, based on either the CPT-4 definition or standard medical practice, would not or could not reasonably be performed at the same session by the same provider on the same patient. Codes representing these services or procedures cannot be billed together.

Outpatient Maintenance Dialysis
Dialysis furnished on an outpatient basis at a renal dialysis center or faciltiy. Outpatient dialysis includes staff-assisted dialysis, self dialysis and home dialysis.

Packaged
Items or services that are deemed integral to performing a procedure or visit are not paid separately in the APC system. They are packaged (also called bundled) into the payment for the procedure or visit. Medicare developed the relative weights for surgical, medical and other types of visits so that the weights reflect the packaging rules used in the APC method. Items or services that are packaged receive a status code of "N".

PASSPORT To Health
A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Prior Authorization (PA)
The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-pay
When a client chooses to pay for medical services out of his or her own pocket.

Provider or Provider of Service
An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

Qualified Medicare Beneficiary (QMB)
QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Reference Lab Billing
Medicaid does not cover reference lab billing. Reference lab billing occurs when a Medicaid provider draws a specimen and sends it to a "reference lab" for processing. The reference lab then sends the results back to the Medicaid provider and bills the provider for the lab service. The Medicaid provider is then expected to bill Medicaid for the lab service. The correct billing procedure is for the lab to bill Medicaid directly for the lab service.

Remittance Advice (RA)
The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Retroactive Eligibility
When a client is determined to be eligible for Medicaid effective prior to the current date.

Sanction
The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Self Dialysis
Dialysis performed by an ESRD patient who has completed an appropriate course of training with little or no professional assistance.

Special Health Services (SHS)
SHS or Children's Special Health Services (CSHS) assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

Specified Low-Income Medicare Beneficiaries (SLMB)
For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down
Clients with high medical expenses relative to their income can become eligible for Medicaid by "spending down" their income to specified levels. The client is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Staff Assisted Dialysis
Dialysis performed by the staff of the center or facility.

Third Party Liability (TPL)
Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Timely Filing
Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
    - the date of service
    - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Usual and Customary
The fee that the provider most frequently charges the general public for a service or item.

Virtual Human Services Pavilion (VHSP)
This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. http://vhsp.dphhs.state.mt.us

Index

D

E

F

N

O

P

Q

R

S

T

U

V

W